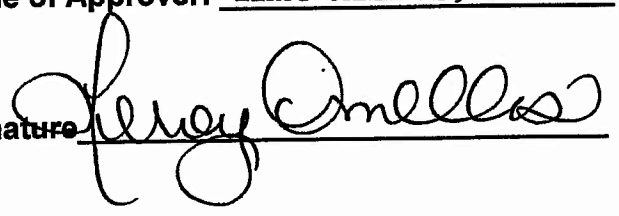
Enclosure B

COUNTY RESPONSE COVER PAGE – MUST BE FULLY COMPLETED AND SUBMITTED WITH PLAN AND DATA

San Joaquin County is requesting participation in the enhanced Anti-Fraud Program and will submit a Plan and Data as described above, by November 1, 2009.

Board of Supervisor Approval

Approved on NOV 2 4 2009 **, 2009, by the County Board of Supervisors**
Name of Approver: LEROY ORNELLAS, Chairman

Signature 

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San Joaquin County

Human Services Agency

and

District Attorney's Office

In-Home Supportive Services Fraud Investigation and Program Integrity Plan

for

2009/2010

November 24, 2009

Contents

Background

San Joaquin County Human Services Agency (HSA) has conducted Quality Assurance (QA) Activities since the mid-1990s to ensure the appropriate expenditure of public funds, and to protect the interest of the clients we serve. With the implementation of the Quality Assurance Initiative in 2004, this county has been committed to the development and implementation of statewide QA activities.

With a focus on prevention and early intervention, this county's mission is to assist and support the In-Home Supportive Services (IHSS) staff to authorize and provide services in a uniform and accurate manner while monitoring program delivery to detect and prevent fraud. A primary focus is to ensure that the consumer's needs are accurately assessed and services delivered at a level that allows them to remain safely at home.

As HSA continues to fairly administer IHSS services, elderly and disabled individuals now enjoy the opportunity to remain secure in their homes. Without these vital IHSS services, clients requiring considerable care would be at risk of placement in higher cost institutional settings.

As with all publicly funding programs, there exists an opportunity for fraud in IHSS. San Joaquin County takes the role of custodian of taxpayer dollars very seriously, and thus performs case reviews to insure compliance with program regulations; responds to data claims matches indicating potential overpayments; implements procedures to identify third party liability; monitors the program to detect and prevent fraud; conducts joint reviews with State staff; detects error trends; identifies training needs; and participates in activities to insure program integrity.

IHSS relies strongly on application information and statements by client service users and service providers. Misrepresentations contained in that information could foster fraud. Fraud may be indicated or demonstrated by the care recipient, the in-home service provider (IP), or in very rare cases, the social worker. Individual and collusive acts to secure an undue benefit are constant threats to the integrity of the IHSS program.

In support of existing QA and fraud prevention activities, San Joaquin County developed and is currently using an IHSS QA computerized program named "Pegasus." Pegasus software is designed to randomly select IHSS cases for QA review; it also enables the use of lap top computers to conduct field reviews. CMIPS download information is used to pre-fill part of the field and desk review form, such as the recipient's name, aid code, case number which must be checked and verified by the QA social worker. Once the QA social worker has completed both reviews this information is automatically filled into the summary.

In addition, the IHSS Program Manger reviews data to identify trends in any facet of service authorization that appears to deviate from the remainder of the data. This data review is used to detect trends or anomalies within a caseload, and determine if further training is required or if an

investigation for potential fraud should occur. Monthly random surveys of clients and providers are also conducted regarding social worker performance to ensure home visits are conducted, and cases are processed appropriately.

The utilization of randomized case selection, coupled with focused reviews, provides a broad based multi-pronged approach to identifying over/under payment issues and fraud. These efforts to insure accurate assessment of needs and the delivery of necessary services result in equitable service delivery to our clients, while effectively safeguarding public funds. It also provides for strong internal control to detect both fraud and issues which require focused training for individual social workers. The random selection of cases by a computerized system eliminates the ability of staff to control cases selected for review, or the staff person who will conduct the review.

IHSS Overpayments/Underpayments

San Joaquin County monitors multiple data sources, and networks with other agencies to prevent, detect and follow-up on overpayments and underpayments. At present, the following areas are monitored on an ongoing basis:

- Income Eligibility Verification System (IEVS)
- Newsprint Obituaries
- San Joaquin County **"Who's in Custody"** website
- Case Management Information and Payroll System (CMIPS) Data for Data Anomalies
- Interface with the Office of Vital Records
- Inter/Intra Agency Networking
    - Social Security Administration – Liaison and Fraud Division
    - Cal-Works
    - Medi-Cal
    - Medi-Cal Long Term Care
- EDS Reports
    - 300 Hour Report
    - Death Match
    - Long Term Care Alerts

In working the issues or concerns identified through the state reports for hospitalization/moved out of state, the following steps are taken:

- Case is retrieved from the IHSS social worker or requested from IHSS case file from storage if the case is closed;
- CMIPS data is reviewed;
- Timesheets are immediately requested from the CMIPs/Fiscal Unit;
- Comparison of the IHSS case file and hours reported on the timesheets to the hospitalization dates or the move out of state;
- If an overpayment is identified, the Overpayment Recovery Process is implemented.

Overpayment Recovery Process: HSA has determined that most potential overpayments result from a recipient's hospitalizations, recipient's deaths, IP terminations. Case record information is compared with the hours reported on the timesheets. If the IP reported and as paid for hours for which they were not entitled:

- An Overpayment File is created with the same copies of information as outlined above for the DHS referral;
- Case comments regarding the overpayment are entered into the case file;
- A request is made for the CMIPs/Fiscal Unit to compute an overpayment;
- Upon completion of the overpayment computation the IP is sent the following:

1. San Joaquin County Overpayment Cover Letter;
2. SJ 135, *Repayment Agreement*;
3. Copies of the timesheets involved;
4. Copy of our Overpayment Calculation.

A copy of this Overpayment packet is placed in the Overpayment file with a copy to the IHSS case file. All overpayment information/data is entered onto an Access spread sheet to facilitate tracking of overpayment cases. If the overpayment is over $800 it is also referred to the DHCS Investigator as detailed above.

If/when the provider signs the repayment agreement letter, they either: 1) send the repayment in full, 2) provide a partial payment, or 3) authorize the county to do an IHSS payroll deduction. This information is updated on the Access spread sheet; a copy is placed in the Overpayment file; a copy is placed in the IHSS case file; and the original is provided to the CMIPs/Fiscal Unit for processing. Should the provider refuse to sign a repayment agreement, or remit payment, they are referred to San Joaquin County Revenue and Recovery for collection of the overpayment.

As noted in Enclosure D, this county has been extremely pro-active to the extent possible in identifying and pursuing overpayments/underpayments. In addition, this county participated in the Data Match Study for Hospital Stays that was conducted in 2006. We are prepared to implement the Hospital Stays component as soon as issues and concerns related to the implementation are resolved at the State level.

San Joaquin County Revenue and Recovery (R&R) is being utilized to collect judgments with penalties, fines and the restitution of funds determined through the court process. The collaboration coordination between the three county Departments (HSA, DAO, and R&R) provides an efficient, cost effective process to identify, investigate and prosecute fraud as well recover funds obtained in a fraudulently.

While every effort is made to prevent underpayments, periodically they do occur. When this is discovered or reported, the social worker in conjunction with their supervisor determines the amount of additional payment which is owed. The case carrying social worker requests appropriate documentation (affidavit from the recipient, time sheets, original application etc.). These documents are reviewed to substantiate the need for additional payment.

Once the underpayment amount is determined, and discussions with all parties involved has occurred, supplemental Time Sheets are issued. The social worker documents the cause of the underpayment in the case record, as well as the remedy agreed upon.

Referrals and Outcomes

Currently, all instances of alleged fraud, including overpayments are referred for initial review by the case carrying social worker and their supervisor. This first level review is for the purpose of determining if an over/under payment has occurred, and what action should be taken to resolve the issue. A component of this initial review is to determine if the error occurred due to lack of information/education on the part of the recipient/provider, or if there is evidence that fraud has occurred.

Fraud referrals have been made in the areas of Grand Theft; Conspiracy; Forgery; Health Care Fraud; Making False/Fraudulent Claims; Presentation of Fraudulent Claims; and Perjury. As outlined in Attachment D, this county has successfully identified and referred for prosecution, a large number of suspected fraud cases.

One area of concern is that due to the fact that the DHCS and periodically the Department of Justice (DOJ) file charges and pursue the case(s), at times the county is not notified of the actual filing date(s) and the subsequent status and outcomes. It is the intent of San Joaquin County through increased coordination with the local District Attorney's Office (DAO), to track this case specific data with weekly updates.

HSA is also proactive in regard to preventing social worker or other staff fraud, through random case record checks by supervisors, QA staff and the Program Manager. This is accomplished through random case reviews selected by a computer program. This methodology reduces the potential for specific cases to be protected from review. This protocol also assists in the detection of training needs for specific social workers, as well as for topics or assessment errors that require training of multiple social workers.

San Joaquin County has had multiple fraud referrals to DHCS result in convictions and restitution being ordered. Restitution is currently being received. In addition, in some cases, restitution has been agreed upon and paid prior to court appearances resulting the case being dropped from prosecution.

Collaboration and Partnership with the District Attorney's Office

HSA and the District Attorney's Office (DAO) have a longstanding relationship involving fraud prevention and investigation. Based on this history, and positive results, there is an expectation of continued success. HSA and DAO have collaborated successfully in areas of Elder Abuse Neglect/Abuse; Child Abuse/Neglect; and Medi-Cal fraud. Individuals benefitting from varied aid or support services are often crossover clientele. This fact becomes more important when data and resources are shared with crossover agencies to provide better informed and appropriate services.

HSA and DAO envision a system of shared information that will offer assistance to those who are most in need. IHSS will be part of a responsive effort with other county teams to accomplish the task of preventing fraud before it has the chance to occur, and investigating fraud aggressively when it is identified. The net result will be a system that delivers efficient, appropriate services with the ultimate goal of elimination of fraud.

HSA intends to continue to focus on the prevention of fraud through the training of staff, elimination of opportunities for fraud, strong internal program review, and focus on the delivery of quality services to seniors and people with disabilities. The DAO intends to continue its aggressive review of suspected fraud cases, conducting subsequent investigations which use effective tools and deductive processes to produce conclusive facts. The focus of the DAO remains to successfully prosecute those responsible for fraud, and to anticipate judgments with penalties, fines and the restitution of funds.

The mission statement of the DAO has been constant: "A commitment to service the County responsibly by prosecuting criminal acts aggressively and fairly." The mission statement of HSA continues to be "To lead in the creation and delivery of services that improve the quality of life for our community." Taken together, these missions commit to ensuring that those in need receive the services that support their optimum independence, while preventing those who seek to take advantage of taxpayer funds through fraud are aggressively and fairly prosecuted.

The San Joaquin County District Attorney's Office will be dedicating a full-time District Attorney Investigator II (DAI) and a full-time District Attorney Investigator Assistant (DAIA) to investigate IHSS fraud. In addition, HSA will be dedicating a full-time social worker and a senior office assistant to collaborate and coordinate with the DAO staff.

HSA will conduct the initial fraud detection activities that have proven to be successful including but not limited to: data-mining; case record review; education/training of social workers, recipients or providers; pulling of time sheets; and examination of signatures; staffing of anomalous data or findings. In addition, the District Attorney's Office will review the current

practices, and provide suggestions and input to enhance the current methodologies in place. Case discussions will be held on a minimum weekly basis to:

- Identify and discuss potential fraud cases;
- Provide inter-disciplinary updates on current activities;
- Provide status of investigations underway;
- Consult regarding alternative methods of investigation/data mining that would improve efficiency and efficacy;
- Track and report outcomes of investigations that have led to prosecution;
- Track status of existing, completed and pending prosecution
- Ensure convicted IPs are placed on the Medi-Cal Suspended and Ineligible Provider List

HSA, DAO and DHCS have held joint conversations regarding the process by which local cases with suspected fraud will be handled. At present, IHSS will continue to forward all fraud referrals to DHCS as required by regulation. DHCS will then work collaboratively with both HSA and DAO to refer/assign specific cases for local investigation and follow-up. A strong commitment exists on the part of all parties to coordinate efforts and foster effective collaboration to address fraud investigation and prosecution processes.

Collaboration with Departments of Health Care Services (DHCS) and Social Services (CDSS)

San Joaquin County has referred suspected fraud cases to the Department of Health Care Services (DHCS) since the inception of our local QA program. At present, a strong collaborative working relationship has been established between staff of DHCS and HSA. Currently, a DHCS investigator confers with QA staff on a weekly basis to receive new referrals, obtain additional information, and provide and update on existing cases. This DHCS investigator also confers with the Program Manager for IHSS on complex cases or as needed. The collaborative working relationship has also resulted in joint meetings between IHSS social workers, providers and/or recipients based on case needs.

HSA staff also works closely with CDSS staff to clarify regulations, laws and requirements on an as needed basis. It is expected that the collaborative efforts put forth thus far by county staff, DHCS and CDS will continue to enhance our ability to identify, investigate, prosecute and obtain restitution for IHSS related fraud. It continues to be the intent of this county to put safeguards in place to minimize if not eliminate, the opportunity for fraud within the IHSS program.

The county will maintain a tracking log that will indicate at a minimum as applicable:

- Case Demographic/Description Information;
- Summary of Suspected Fraud
- Current Status of Investigation/Prosecution
- Current Lead (agency/individual)
- Pending Action
- Court Jurisdiction
- Current Disposition
- Final Disposition
- Restitution Determination
- Restitution Status/Tracking
- Conviction Status/Term/Location

Other data elements will be gathered as deemed necessary and/or appropriate by county or state agencies.

Tracking & Reporting Data & Activities

In the absence of directions to the contrary, San Joaquin County plans to continue to track case specific data with all elements that we currently anticipate will be required by CDSS. This county is confident that it will accurately and fully track all necessary data, and has the ability to submit that data information in a format that will meet CDSS requirements, as we already gather and track a substantial amount of information. We encourage CDSS to continue to work collaboratively with counties to implement a data collection system that will accurately reflect activities and outcomes in a uniform, objective and statistically relevant manner.

As planning for fraud prevention and intervention activities is an ongoing process, we are confident that we will have the ability to submit Fraud Prevention & Intervention plans to CDSS on an annual basis no later than June 1st of each year. This plan will include a summation of activities for the preceding year, as well as any relevant updates for the upcoming year.

This county will commit to tracking, reporting, and submitting final data reports for the previous fiscal year to CDSS by August 1st of each subsequent year.

Current Anti-Fraud Activities

As noted previously, San Joaquin County has been very pro-active in detecting and referring suspected fraud for further investigation and prosecution. The collaborative relationship that is enjoyed with DHCS is but one example of the dedication to minimize if not eliminate, fraud within the program. We will continue to perform data-mining activities; consult with other counties regarding best practices; consult with CDSS and DHCS for clarification and guidance as needed; and train current as well as future staff on fraud detection methods.

Potential fraud referrals are received from IHSS social workers, QA staff, other HSA staff, outside agencies or community members. When the referral is received, the suspected fraud could involve the recipient, the provider or both. When a report of suspect fraud is received, the following activities occur

- Department of Health Care Services (DHCS) fraud file is created;
- Print outs of all the relevant CMIPs screens (RELA, RELB, RELC, and PELG) are obtained and placed in the file;
- The MC 609, *Confidential Medi-Cal Complaint Report* is created;
- The alleged suspect information is compared to those receiving any aid (Cash, Food Stamps, Medi-Cal) and MEDS.
- If the alleged fraud is against the Individual Provider (IP) and the IP has not reported their IHSS income to their Eligibility Worker (EW) the EW is alerted and provided copies of the providers IHSS income verification for a possible AFDC/FS overpayment/over-issuance.
- Time Sheets relevant to the investigation are requested from involved from the CMIPs/Fiscal Unit.
- The IHSS case is retrieved from the social worker or storage if case is closed. Copies of the written case comments and the following forms are obtained:
    1. SJ 415 *Acknowledgement of Explanation of Rights and Responsibilities and Consent to Release Information*;
    2. SOC 295, *Application for Social Services*;
    3. SJ 190, Motor *Voter Form*, SOC 426;
    4. *Personal Care Services Program Provider/Enrollment Agreement*;
    5. Copies of the IP's photo identification and Social Security card.

This documentation (note: the SJ 415, SOC 295, and SJ 190 are for signature comparisons, if needed) and the death verification if applicable are reviewed with the Program Manger, and subsequently referred to DHCS. If the fraud referral involves an IHSS overpayment, such as from a hospitalization or a recipient death, copies of HSA's overpayment cover letter; the SJ 135 *Repayment Agreement*; copies of the Time Sheets; and a copy of our Overpayment Calculation sheet are also included.

All the fraud/overpayment information/data is entered on an Excel spread sheet to facilitate tracking and status of each case. A copy of the DHS referral is maintained, with a copy to the IHSS case file.

DHCS referrals are sealed, maintained in a secured location, and hand-delivered to the DHCS Investigator, usually on a weekly basis. DHCS has agreed to review these cases promptly, and refer cases to the San Joaquin County DAO for investigation with HSA, and provides a copy of the completed investigation and the *Complaint Acknowledgement/Status Report* showing whether a violation, criminal filing, etc. has occurred. This information is entered into the Excel spread sheet and a copy is place in the IHSS case file.

HSA had developed a sophisticated tracking system that documents both the searching of the data bases mentioned, and any findings that warrant further investigation. Anomalous findings are recorded and analyzed by a QA Staff Analyst, and subsequently reviewed with QA staff, the IHSS social worker, supervisor and/or Program Manager as necessary or appropriate. Support staff are utilized to "pull" time sheets, payroll records, case documents etc. to provide for more in depth analysis. Once the preliminary review is completed, a determination is made regarding the next steps to resolve the anomalous findings.

These steps could involve education/training of the social worker; further investigation or interviews with the recipient or provider; training/education of the provider or recipient; request for restitution of overpayments; or referral for fraud investigation through the Department of Health Care Services (DHCS).

We will continue to monitor the program internally, to prevent fraud from the program level as well as monitor for fraud through either the provider, recipient, or any combination thereof.

Proposed Anti-Fraud Activities

With the augmented funding, this county plans to add the skill, knowledge and expertise of the District Attorney's Office to HSA's existing anti-fraud activities, as well as expand HSA focus and follow-up. With the addition of a DAI and a DAIA, San Joaquin County will be able to pursue fraud investigations that to this point have not been possible. These investigations will include, but not be limited to:

- Protective Supervision cases that lack of mandated supervision is suspected;
- Functional Limitation claims that are suspected to be overstated by the recipient;
- Living situations that are suspected to be falsely reported;
- Unreported changes in household composition;
- Recipient demanding Provider share their check;
- Provider demanding additional payments from the client;
- Verification of Provider performance of services claimed on the Time Sheet; and
- Misrepresentation of income.

The plan will include unannounced visits by either the social worker, DAI, DAIA or a combination of these professionals; surveillance of residences, recipients, providers; filing for liens to collect restitution; increased detailed focus on review of Time Sheets; increased review of Warrants issued for payment; increased data collection; and ultimately increased prosecution and restitution.

The DAO DAI will be fully dedicated to review and investigate fraud in IHSS. This investigator class works under more independent supervision, and possesses skills to locate, identify, assemble, preserve, record and evaluate information and facts related to fraud. This investigator will be integral to the success of the IHSS integrity efforts, with a strong focus on the prevention as well as the detection of fraud.

Complex investigations of fraud by a DAI dictate a range of activities, contacts and evidence gathering. As such, complete, effective criminal investigations and duties may include:

- Preparation and execution of search warrant(s)
- Physical arrests
- Testifying at trial as to facts
- Unannounced home visits
- Observations to determine if services are being provided
- Canvassing/contact in recipients' neighborhoods
- Surveillance of recipients and/or IP activities
- Review of bank reconciliation records
- Review/update recipient assets
- Review of financial documents to expose unreported income

- Review of vehicle registrations
- Review of providers' past and current work history
- Review of criminal histories
- Check of calendared appointments
- Conduct interviews with recipients, IPs, family, associates and acquaintances
- Consider any evidence of non-compliance with regulatory guidelines.

The DAIA will be dedicated to performing, under general supervision the routine technical and investigative work in support of IHSS investigations. Those tasks may include: locating witnesses; maintaining records or reports; preparing documents' requesting financial data records' research; and other support activities. This position will afford the CI the support necessary to conduct complete and effective investigations.

The IHSS Program Manager, Social Worker, DAI and DAIA will meet on a regular basis to ensure rapid progress and coordination in the county's focus on the prevention or detection of fraud within IHSS. Through coordination with the DAO, internal investigation of potential fraud within the county or program staff will be strengthened via third party reviews.

To optimize the effectiveness of field investigation, laptop computers will be provided to the DAO and HSA field staff, and dedicated to IHSS fraud detection. In addition, initial fraud funds will be utilized to purchase system tools that employ the use of fingerprint scans and database checks to authenticate identity. The *Blue Check Mobile Identification Device* and the *Mobile II* allow field investigators to confirm on-site and within three minutes that an individual's identity statement is true. This check will both prevent undue disbursements of services and funds, and discourage attempts to defraud IHSS guidelines. This system interfaces with both cellular phones and mobile laptops to offer quick response to inquires. This system will complement the LiveScan process that will be implemented to fingerprint all new providers who begin work after November 1, 2009, and all existing providers prior to July 1, 2009.

Unannounced home visits will be conducted by both DAO and HSA staff as determined through joint consultation. Conducting these visits is an effective tool to confirm the delivery of services, as well as compliance with regulations by recipients and IPS.

The absence of a provider at the recipient's dwelling is a prime component of many fraud investigations. The DAO has identified that the tracking of the movement of vehicles used by providers is an effective means to identifying fraudulent and deceptive acts. The county plans to purchase and utilize *Covert Tracker* global positioning systems to monitor suspected non-compliant acts involving vehicle use. This system interfaces with lapto computer programming capable of real time tracking. The DAO's experience with devices of this type indicates that it saves excessive surveillance costs and hours, while accomplishing a stronger evidentiary result.

Traditional surveillance and evidence gathering tools will also be utilized. Digital still, movie cameras will be used to record the activities of recipients suspected of over-reporting their level of disability; the presence/absence of 24 hour services for Protective Supervision cases; and digital voice recorders for memorializing statements made by recipients and IPs.

To optimize coordination and knowledge between social services and DAO staff, cross trainings will occur. The DAO will provide focused training on evidentiary documentation; field safety etc. and HSA will provide focused training on functional impairment; functional limitations of certain disabilities/diagnoses; IHSS regulations etc.

HSA has also worked closely with San Joaquin County Public Health, and will soon be able to interface with their database on a weekly basis to identify recipient deaths more quickly. This will assist to discontinue cases promptly to prevent overpayments to providers before they can occur. While overpayments will still occur, those resulting from a delay in reporting the death of a recipient will be reduced significantly.

The state, county and the IHSS program will all benefit from the success of IHSS integrity and fraud prevention. Overpayments will be recovered; misuse of benefits prevented or detected; non-compliance issues identified; and internal program integrity preserved. Locally, both the DAO and HSA are committed to the success of the Fraud Prevention and Investigation Program.

Integration of Existing Program Integrity Efforts into the Fraud Plan

Currently, HSA develops a Quality Assurance Plan on an annual basis. This QA Plan is developed utilizing existing CDSS guidelines, and is submitted for approval based upon state proscribed timelines. This QA Plan was the basis for the initial fraud components that have already been implemented within the county system. As such, it is anticipated that the integration of the existing QA Plan with the Fraud Plan will be seamless.

In fact, it is recommended that CDSS integrate the Fraud Plan guidelines, requirements, reports, etc. into a single Plan of which fraud investigation and follow-up is a component. This approach will assist individual counties to develop a continuum of activities that most closely mirrors the intent of the Legislature while protecting the integrity and goals of the IHSS program.

Currently, all instances of alleged fraud, including overpayments are referred for review by the case carrying social worker and their supervisor. This first level review is for the purpose of determining if an over/under payment has occurred, and what action should be taken to resolve the issue. A component of this initial review is to determine if the error occurred due to lack of information/education on the part of the recipient/provider, or if there is evidence that fraud has occurred.

Fraud referrals have been made in the areas of Grand Theft; Conspiracy; Forgery; Health Care Fraud; Making False/Fraudulent Claims; Presentation of Fraudulent Claims; and Perjury. As outlined in Attachment D, this county has successfully identified and referred for prosecution, a large number of suspected fraud cases.

Annual Outcome Report

By submission of this plan, San Joaquin County commits to the submission of an Annual Outcome Report by August 1st of each year. This report will detail activities and data reflective of activities that have occurred related to fraud detection, investigation, intervention, and prosecution. While no information is currently forthcoming regarding the format or details the state desires in this annual report, this county is fully confident that full compliance with this requirement.

San Joaquin County plans to continue to track case specific data with all elements that we currently anticipate will be required by CDSS. This county is confident that it will accurately and fully track all necessary data, and has the ability to submit that data information in a format that will meet CDSS requirements, as we already gather and track a substantial amount of information. We encourage CDSS to continue to work collaboratively with counties to implement a data collection system that will accurately reflect activities and outcomes in a uniform, objective and statistically relevant manner.

As previously stated, this county will commit to tracking, reporting, and submitting final data reports for the previous fiscal year to CDSS by August 1st of each subsequent year.

Enclosure D

County: **San Joaquin**

Overpayments identified by County QA		04/05	05/06	06/07	07/08	08/09
Total Amount per Fiscal Year:		$ 24,225.79	$ 21,706.08	$ 36,898.37	$ 66,893.36	$ 59,911.38
Breakdwon of Causes	Number of Instances:	13	12	56	95	35
	Provider:	13	12	56	95	35
	Recipient:	0	0	0	0	0
	County Error:					
	Unkown:					
	Other:					

Underpayments identified by County QA		04/05	05/06	06/07	07/08	08/09
Total Amount per Fiscal Year:		$ -	$ -	$ -	$ -	$ -
Breakdwon of Causes	Number of Instances:	0	0	0	0	0
	Provider:	0	0	0	0	0
	Recipient:	0	0	0	0	0
	County Error:					
	Unkown:					
	Other:					

Fraud Referrals/Outcomes		04/05	05/06	06/07	07/08	08/09
Number of referrals to DHCS:		32	47	54	49	23
Number handled locally by DA:		0	0	0	0	0
Number of convictions:			1	2	6	1
Court Ordered Restitution:			$ 10,196.88	$ 13,716.92	$ 13,013.49	$ 3,122.50
Amount of funds involved in the convictions:			$ 10,196.88	$ 13,716.92	$ 13,013.49	$ 3,122.50
Amount of funds recovered:			$ 5,660.62	$ 4,873.96	$ 6,725.77	$ -
Amount of funds pending recovery:			$ 4,536.26	$ 8,842.96	$ 6,287.72	$ 3,122.50
Basis for the Conviction:						
Individuals Responsible	Recipient:					
	Provider:					
	County Staff:					
	Other:					
	Unkown:					

Enclosure D

County: **San Joaquin**

Page Two

Utilization of County DA for Fraud		04/05	05/06	06/07	07/08	08/09
Documented referrals to DA*		9	1	0	23	1
Outcomes	Accepted:					
	Rejected:	9	1		23	
	Pending:					1
	Completed Investigation					
	No Fraud:					
	Restitution Action:					
	Referred for Prosecution:					
	Criminal Charges Filed:					
	No Charges Filed:					
	Convictions:					
	Acquittals:					
	Dismissals:					
	Pending Investigation:					
	Restitution					
	Court Ordered:					
	Restitution Action:					
	Fines					
	Prosecutions Completed					
	Convictions					
	Misdemeanor					
	Felony					

Budget Justification
San Joaquin County's Fraud Funding Plan for FY 2009-10

Budget Section	Total
A. Personnel Costs (includes employee benefits)	$ 77,642
B. Operating Expenses	$ 202,552
C. Equipment Expenses	$ 6,900
D. Travel/Per Diem and Training	$ 11,120
E. Subcontracts and Consultants	$ 101,866
F. Other Costs	$ 0
G. Indirect Expenses	$ 2,798
Total Expenses	**$ 402,878**

A. Personnel Costs (including employee benefits)	Total Budget
Title: Social Worker III **Salary Calculation:** $2,360.80 x 13 pay periods = $30,690 in salaries + parking ($221 for 6 mos), UI at 0.3% ($92), Retirement 25.2% ($7,734), Social Security 6.2% ($1,903), Medicare 1.45% ($445), Life Insurance ($21 for 6 mos), Health Ins ($4,972.50 for 6 mos), Dental ($288 for 6 mos), Vision ($36 for 6 mos) **Duties Description:** Social Worker position will perform initial fraud detection, including unannounced visits, review of timesheets, signatures, and other documents. Coordinate with law enforcement, District Attorney, and other professional staff.	$ 46,402.50
Title: Sr. Office Assistant **Salary Calculation:** $1,484.80 x 13 pay periods = $19,302 in salaries + parking ($221 for 6 mos), UI at 0.3% ($58), Retirement 25.2% ($4,864), Social Security 6.2% ($1,197), Medicare 1.45% ($280), Life Insurance ($21 for 6 mos), Health Ins ($4,972.50 for 6 mos), Dental ($288 for 6 mos), Vision ($36 for 6 mos) **Duties Description:** Provide assistance in the duties performed by the Social Worker, including data and document collection, copying, mailing, delivery, and other office support functions.	$ 31,239.50
Title: **Salary Calculation:** **Duties Description:**	$
Total Personnel Costs:	**$ 77,642**

B. Operating Expenses	Total Budget
Title: Office Supplies & Expenses **Description: Includes Office Supplies, Printing & Binding, Copier Rental, and Postage**	$ 3,650
Title: Space Costs & Communications	$ 2,744

Description: Space, utilities, maintenance, phone bills and related expenses	
Title: Special Department Expenses **Description: Fraud Prevention Activities, brochures, training materials, etc.**	$ 193,558
Title: Small Tools & Instruments **Description: Electronic and other tool items under $1,000 per unit**	$ 2,600
Total Operating Expenses:	**$ 202,552**

C. Equipment Expenses	Total Budget
Title: Equipment **Description: Video Cameras & Surveillance/Idenity Equipment**	$ 3,000
Title: Automation Equipment **Description: Laptops/Computers, Printers**	$ 3,900
Title: **Description:**	$
Total Equipment Expenses:	**$ 6,900**

D. Travel/Per Diem and Training	Total Budget
Title: Motorpool **Description: Costs for renting vehicles from County Motorpool**	$ 11,120
Title: **Description:**	$
Title: **Description:**	$
Total Travel/Per Diem and Training:	**$ 11,120**

E. Subcontracts and Consultants	Total Budget
Title: Professional Services - District Attorney Costs **Description: One District Attorney Investigator and One Asst District Attorney Investigator, both dedicated to IHSS Fraud Prevention**	$ 96,794

Title: Professional Services **Description: Information Systems staff and other professional services from other County Departments and/or outside resources**	$ 5,072
Title: **Description:**	$
Total Subcontracts and Consultants:	**$ 101,866**

F. Other Costs	**Total Budget**
Title: **Description:**	$
Title: **Description:**	$
Total Other Costs:	**$**

G. Indirect Expenses	**Total Budget**
Title: County Indirect Charges (A-87) **Description:** Indirect allocated expenses related to County Counsel, Human Resources, County Administrator's Office, etc.	$ 2,798
Title: **Description:**	$
Total Other Costs:	**$ 2,798**